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Name _____ Birth date: ____/____/____

1) **List Health Concerns in Order of Importance?**

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

2) **Allergies** (drugs, food, environmental)

3) **What are your Expectations for Today's Visit?**

4) **What expectations do you have of me as your physician?**

5) **What behaviors or habits do you engage in regularly that support your health?**

6) **What behaviors or habits do you engage in regularly that are self destructive lifestyle habits?**

7) **What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health?**

8) **Have you seen a Naturopathic Physician before?** ___No ___ Yes, name _____
Other Holistic Practitioners? _____

9) **List Medications, Vitamins, Herbs and dosages you are taking** (including Aspirin, birth control)

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

10) **Hospitalizations** (dates, type of illness)

11) **Date of Last Physical Exam:** _____

Date and Location of Last Blood Work: _____

Women Only: Last Annual Exam: _____ Results: _____

Number of pregnancies: _____ Number Births: _____

Hysterectomy: ___ no, ___yes, date _____ Reason: _____

12) **Any family history of the following** (circle which apply) State relationship to you

Asthma _____ Heart Disease, Stroke _____

Arthritis _____ High Blood Pressure _____

Cancer _____ Hepatitis _____

Diabetes _____ Thyroid _____

Other: _____

Review of Systems check all that apply to you

General

- Chills
- Fever
- Weight loss
- Fatigue

Neurological

- Headache frequent
- Fainting
- Tremors
- Dizziness
- Seizures

Musculoskeletal

- Muscle weakness
- Muscle pain
- Back/neck pain
- Joint pain/swelling
- Numbness

Cardiovascular

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Swelling of ankles
- Varicose Veins

Gastrointestinal

- Poor Appetite
- Bloating
- Constipation
- Diarrhea
- Vomiting, persistent
- Vomiting blood
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach pain

Endocrine

- Excessive thirst
- Excessive hunger
- Hormonal imbalance
- Heat/cold intolerance

Genito-urinary

- Blood in urine
- Frequent urination
- Poor bladder control
- Painful urination

Eye, Ear, Nose, Throat

- Bleeding gums
- Blurred vision
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Ringing in ears
- Sinus problems
- Vision – Halos

Psychiatric

- Nervousness/agitation
- Depression
- Suicidal thoughts
- Mental illness

Skin

- Bruises easily
- Hives
- Itching
- Changes in moles
- Rash

Men Only

- Breast lump
- Erection difficulties
- Lump in testicles
- Sore on Penis

Women Only

- Abnormal pap
- Mid cycle bleeding
- Breast lump
- Menstrual Cramps
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge

Respiratory

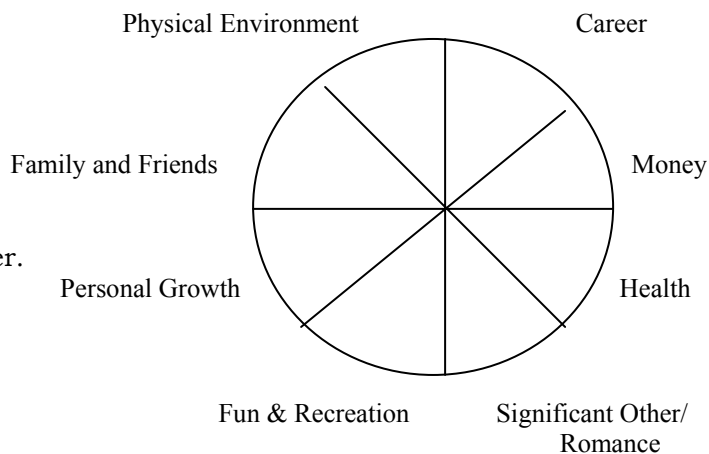
- Persistent cough
- Shortness of breath
- Wheezing
- Coughing up blood

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area it relates to you. 0-100%

For example, if you are extremely happy in your career, shade the entire pie shape for your career.

Do the same for each area, starting from the center point radiating outwards. Mark in percentage your level of satisfaction



Health and Lifestyle Habits

Sexual Preference: Heterosexual ____ Homosexual ____ Bisexual ____

Currently Sexually Active: no ____ yes ____ are you practicing safe sex? _____

Birth Control Method _____ History of Sexually Transmitted Disease _____

Diet Restrictions? _____

Satisfied with Diet? NO, Why? _____

Weight changes in last 3 years? _____

Smoke Cigarettes or Recreational Drugs or Past History? _____

Caffeine Intake: _____ Alcohol Intake: _____ Water Intake: _____

Any major childhood illnesses or physical or emotional upsets?

Any additional information you would like to add....

Thank you for your time and effort. I look forward to working with you.